STATEMENT OF
TERRY TRACY, DEPARTMENT SERVICE OFFICER
THE AMERICAN LEGION
BEFORE THE
CAPITAL ASSET REALIGNMENT FOR ENHANCED SERVICES
(CARES) COMMISSION
ON
THE DRAFT NATIONAL CARES PLAN

OCTOBER 1, 2003

Mr. Chairman and Members of the Commission:

Thank you for the opportunity today to express the local views of The American Legion on the Department of Veterans Affairs' (VA)'s Capital Asset Realignment for Enhanced Services (CARES) initiative as it concerns Veterans Integrated Services Network (VISN) 21. As a veteran and stakeholder, I am honored to be here today.

The CARES Process

The VA health care system was designed and built at a time when inpatient care was the primary focus and long inpatient stays were common. New methods of medical treatment and the shifting of the veteran population geographically meant that VA's medical system was not providing care as efficiently as possible, and medical services were not always easily accessible for many veterans. About 10 years ago, VA began to shift from the traditional hospital based system to a more outpatient based system of care. With that shift occurring over the years, VA's infrastructure utilization and maintenance was not keeping pace. Subsequently, a 1999 Government Accounting Office (GAO) report found that VA spent approximately $1 million a day on underused or vacant space. GAO recommended, and VA agreed, that these funds could be better spent on improving the delivery of services and treating more veterans in more locations.

In response to the GAO report, VA developed a process to address changes in both the population of veterans and their medical needs and decide the best way to meet those needs. CARES was initiated in October 2000. The pilot program was completed in VISN 12 in June 2001 with the remaining 20 VISN assessments being accomplished in Phase II.

The timeline for Phase II has always been compressed, not allowing sufficient time for the VISNs and the National CARES Planning Office (NCPO) to develop, analyze and recommend sound Market Plan options and planning initiatives on the scale required by the magnitude of the CARES initiative. Initially, the expectation was to have the VISNs submit completed market plans and initiatives by November, 2002, leaving only five months to conduct a comprehensive assessment of all remaining VISNs and develop recommendations. In reality, the Market Plans were submitted in April 2003. Even with the adjustment in the timeline by four months, the Undersecretary for Health found it necessary in June 2003, to send back the plans of several VISNs in order for them to reassess and develop alternate strategies to further consolidate and compress health care services.

The CARES process was designed to take a comprehensive look at veterans' health care needs and services. However, because of problems with the model in projecting long-term care and mental health care needs into the future, specifically 2012 and 2022, these very important health care services were omitted from the CARES planning. The American Legion has been assured that these services will be addressed in the next "phase" of CARES. However, that does not negate the fact that a comprehensive look cannot possibly be accomplished when you are missing two very important pieces of the process.

The American Legion is aware of the fact that the CARES process will not just end, rather, it is expected to continue into the future with periodic checks and balances to ensure plans are evaluated as needed and changes are incorporated to maintain balance and fairness throughout the health care system. Once the final recommendations have been approved, the implementation and integration of those recommendations will occur.

Some of the issues that warrant The American Legion's concern and those that we plan to follow closely include:

- Prioritization of the hundreds of construction projects proposed in the Market Plans. Currently, no plan has been developed to accomplish this very important task.
- Adequate funding for the implementation of the CARES recommendations.
- Follow-up on progress to fairly evaluate demand for services in 2012 and 2022 regarding long-term care, mental health, and domiciliary care.

VISN 21- NORTH VALLEY, SOUTH VALLEY, AND SIERRA NEVADA MARKETS

North Valley Market

The North Valley Market encompasses the northern interior of California through rural northern California and the Sacramento Valley. There are 14 counties that make up this market with several facilities scattered throughout the geographic area including the Sacramento VA Medical Center.

The Draft National Plan (DNP) proposes to meet the increase in demand in outpatient services by expanding several of the Community Based Outpatient Clinics (CBOCs), increasing services at the parent facility and leasing space.

There is an enhanced use lease proposal being developed in Sacramento involving long-term care. The American Legion has no objection to this proposal as long as the veteran and VA both benefit from the plan.

The North Valley Market is exploring sharing opportunities with the Department of Defense (DoD) at Travis Air Force Base. These agreements would potentially enhance access to inpatient care, primary care and specialty care. Again, The American Legion supports VA/DoD sharing, however, we must ensure that veterans do not get categorized as second class citizens behind the active duty service member. Also, DoD has not always been supportive of sharing agreements. VA must ensure that DoD is willing to participate before they hang their hat on plans that may not come to fruition.

South Valley Market

The South Valley Market is serviced by VA Central California health Care System (CCHCS) located in Fresno. There is also a Geriatric Extended Care Unit located in Fresno.

CCHCS has strong affiliations with 30 educational facilities to train health care professionals in many diverse disciplines. The American Legion is a strong supporter of affiliations and we consider them a vital and important link in maintaining the overall viability and quality of VA health care, particularly in the specialty areas. Affiliations are major stakeholders in the CARES process and their presence at the table is very important.

The CCHS has a very active research program as well with 18 active research projects and several principal investigators. Their total research budget is over a quarter of a million dollars. Again, The American Legion believes the viability of a strong research program is significant to the overall delivery of veterans' health care and we are dedicated to maintaining the proper funding to allow this very important VA research program to continue.

With regard to the seismic issue, the VISN has proposed construction projects at the Fresno facility. The American Legion supports an aggressive plan to address patient safety issues and unsound structural problems.

Sierra Nevada Market

The Sierra Nevada Market is comprised of 12 counties in northern Nevada and eight counties in northeastern California, and includes the Lake Tahoe Region. The VA Sierra Nevada Health Care System (VASNHCS) is located in Reno.

The biggest issue concerning this market with regard to the CARES initiative is the tertiary care access gap. Currently 70 percent of the enrollees must drive greater than four hours to access VA tertiary care services.

The Draft National Plan (DNP) proposes to expand specialty services in Reno and contract out locally. In the original market plan submitted by the VISN, this was basically their recommendation to solve this issue also. By expanding specialized services in Reno, referral to the Bay Area for outpatient procedures would be reduced, which would then reduce the number of veterans forced to drive so far for care.

The American Legion recommends VA look at the plan for this area again. With 70 percent of the veterans outside the standard set by the CARES process for access to tertiary care, it is hard to believe that simple expansion of current services is an adequate solution.

VISN 21-NORTH COAST, SOUTH COAST, AND PACIFIC ISLAND MARKETS

Campus Realignment/Consolidation of Services

The Livermore Division is part of the VA Palo Alto Health Care System. It is located approximately forty miles east of Palo Alto, California. Currently, the facility provides geriatric inpatient services, primary, subspecialty and ancillary outpatient services. The Draft National Plan (DNP) proposes to close the Livermore facility. The Plan recommends the transfer of the nursing home services to Menlo Park and contracting in the community. It further recommends that outpatient services transfer to the San Joaquin Valley Community Based Outpatient Clinic (CBOC) and a new East Bay CBOC.

The American Legion cannot support this proposal as it has been presented in the DNP. The Menlo Park Division is approximately 40 miles and an estimated drive time of nearly an hour from Livermore, with no traffic. Many senior veterans receive their care at Livermore and this proposal would force a hardship on them that they may not be able to handle. The original VISN plan did not recommend closure of the facility. A more in depth study of the demographics of this area should be completed before any decisions are made as to where veterans receive their care. The American Legion can see no enhancements to services in this proposal, merely capital asset realignments.

The American Legion remembers the experiences encountered by the veterans who were affected by the closure of Martinez in 1991 and their difficulties in obtaining health care. We do not want to see history repeated.

Outpatient Services

The CARES analysis projects an increase in the demand for primary care and specialty care in these markets, indeed throughout the VISN. The DNP proposes to meet this demand in several ways. There is planned expansion of existing space, expanded hours,

and telehealth. The American Legion would like to see a more defined plan for meeting the future demand.

Collaboration

In the Pacific Island Market, which encompasses Hawaii, the VISN is proposing to expand their agreements with Tripler Air Force Base. Expanding these agreements will enhance access to tertiary care, acute care, as well as meet the primary and specialty outpatient care demands. The American Legion supports sharing with the Department of Defense (DoD) and we would like to see VA pursue every opportunity presented to them. The American Legion notes that if there is "good faith" partnering exhibited by both agencies then everyone involved wins.

Seismic Issues

The American Legion is pleased to see seismic issues being aggressively addressed in the DNP. The safety of the patients and employees at VA facilities should not be gambled with. The risk is too high not to address those buildings that are structurally unsound. The American Legion has testified on many occasions on the absurdity of under funding major and minor construction. VA has been unable to address the seismic problem in the manner in which we would like them to due to this chronic under funding.

Thank you for the opportunity to be here today.

STATEMENT OF
GEORGE H. STEESE, JR.
PAST NATIONAL COMMANDER
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
CAPITAL ASSETS REALIGNMENT FOR ENHANCED SERVICES COMMISSION
LIVERMORE, CALIFORNIA
OCTOBER 1, 2003

Mr. Chairman and Members of the Commission:

On behalf of the VISN 21 members of the Disabled American Veterans (DAV) and its Auxiliary, I am pleased to express our views on the proposed Capital Assets Realignment for Enhanced Services (CARES) Market Plans for this area in VISN 21.

For more than 80 years, DAV has been dedicated to a single purpose: building better lives for America's disabled veterans and their families, serving some four generations of America's heroes. The Department of Veterans Affairs (VA) has shared in this commitment by providing a health care system, second to none, which is of the utmost importance to the DAV and our members.

The VA health care system's primary mission is the provision of health care to our nation's sick and disabled veterans. VA's Veterans Health Administration (VHA) is the nation's largest direct provider of health care services, with 4,800 significant buildings. The quality of VA care is equivalent to, or better than, care in any private or public health care system. VA provides specialized health care to the men and women who were injured due to their military service. Its specialized services for veterans with war-related injuries in the areas of blind rehabilitation, spinal cord injury care, posttraumatic stress disorder treatment, and prosthetic services could not be matched in the private sector. Much of the research performed by VA staff has had far-reaching effects and benefited not just veterans, but private citizens as well.

As part of the CARES process, VA facilities are being evaluated to ensure VA delivers more care to more veterans in places where veterans need it most. DAV is looking to CARES to provide a framework for the VA health care system that can meet the needs of sick and disabled veterans now and into the future. On a national level, DAV firmly believes that realignment of capital assets is critical to the long-term health and viability of the entire VA system. We do not believe that restructuring is inherently detrimental to the VA health care system. However, we have been carefully monitoring the process and are dedicated to ensuring the needs of special disability groups are addressed and remain a priority throughout the CARES process. As CARES has moved forward, we have continually emphasized that all specialized disability programs and services for spinal cord injury, mental health, prosthetics, and blind rehabilitation should be maintained at current levels as required by law. Additionally, we will remain vigilant and press VA to focus on the most important element in the process, enhancement of services and timely delivery of high quality health care to our nation's sick and disabled veterans.

VISN 21 DAV members are well aware of the proposed CARES Market Plans and how the proposed changes would affect the many disabled veterans in the communities being served. The handbook for Market Plan Development clearly defines and provides guidance for the implementation of the CARES initiative. Within the Market Plan, access planning and capacity planning have been flagged as the two most prevalent initiatives concerning this VISN.

Currently, the VA medical centers in the Bay area serve veterans from as far north as the California/Oregon border to the San Luis Obispo area in the south. The stretch is well over 1,000 miles, and a large portion of the veterans served live in remote areas. Transportation to and from VA facilities has and will continue to be of great concern, not only to veterans and their families, but also to the DAV, as we provide as much support as we can with our Transportation Network. Each and every facility has its unique population of sick and disabled veterans that require continued care. The VA, over the past several years, has had a campaign to enroll as many veterans as possible. Veterans signed up for services and, in many cases, dropped the very costly health insurance they had been using, but could no longer afford on a fixed income. The VA reached out to the community through special events and promised it would be there to serve these veterans. If the VA were to pull out now, many veterans would go without much needed medical care as they cannot afford to pick up the costly insurance they gave up. Additionally, Vietnam era veterans, now in their fifties and sixties, are becoming more dependent on an overly taxed VA health care system.

In the North Valley Market, the Sacramento VA Medical Center at Mather has constructed a new hospital facility in order to provide better care to its veterans community. Although welcomed, a large percentage of clientele reside in surrounding cities that are quite a distance away from the Mather location. Grass Valley, Placerville, Marysville, and Chico are just a few neighboring cities plagued with insufficient VA medical care outlets. The result, complaints regarding the lack of VA transportation to these cities, remains constant. One client this service organization represents actually hitchhiked to his medical appointment because he had no other mode of transportation. His disability medication simply precluded him from driving. When he questioned VA transportation coordinators about the problem, he was told that he was not within area limits to receive transportation assistance. Yes, a new VA hospital is wonderful. However, greater access would be well received by this veterans' community.

The VISN Access Planning Initiative addresses improved access to care for enrolled veterans as the objective. This initiative would solve the many problems facing our disabled veterans concerned about medical care access. Written in the "Assessment of Current Environment" section under the Access Planning Initiative heading, consideration is given to transportation and geographic barriers that veterans face in accessing medical care. This will enable 70% of veteran enrollees to be within primary care driving time guidelines, which would be 60 minutes for highly rural areas. This would be welcomed by many members of the DAV in VISN 21, who must currently travel three and four times that long for their appointments.

Access to emergency care for service-connected veterans has also long been a concern of our members who live in the outlying areas of the VISN. Redding is a good example: a veteran rated at 100% presented to a private hospital, while having a heart attack. Due to the distance to a VA medical facility for inpatient services, the individual was required to stay in the private

facility for five days. The VA refused to pay for the treatment, which placed a significant financial burden on the veteran's family. Had the VA had better transportation abilities, the veteran would have been transported to the nearest VA once his medical condition was stable, and this financial burden and stress would have been avoided. A concern facing veterans in the Sacramento area is the scheduling of appointments with a primary care physician. As it stands, veterans wishing to see their primary care person requesting an appointment in June will be lucky to see a doctor in October or November. This type of turnaround time in scheduling is unacceptable.

The VISN 21 Executive Summary speaks of increasing primary care demand in all six markets. This demand would be met by expanding existing Community-Based Outpatient Clinics, as well as increasing services at other parent facilities. Expanded hours to increase capacity were also proposed. I have personally witnessed the changes happening in the VA Central California Health Care System and, as with any new program, bugs must be worked out, but it is definitely a step in the right direction. We can rest assured that the care will be there for future disabled veterans if the VA remains committed to serving the sick and disabled veterans as close to home as possible.

Knowing that it is not always feasible for every facility to have every specialty, we are pleased that the CARES process takes into consideration the collaborative opportunities between facilities under the "Assessment of Current Environment." This is a plus for veterans to receive the best medical care available by the best medical teams available. A winning situation for the veteran, as other treatment avenues are open for delegation. The Capacity Planning Initiative would lower an already seemingly endless backlog by diverting overflow traffic to facilities who aren't operating at full capacity. In order for this to work however, consideration must be given to the ability of veterans to get that care. This sometimes can be the hurdle that one cannot get over, and causes them to forfeit the game.

In closing, I would like to thank the Commission for holding these hearings to hear the concerns of the local veterans. Questions will always arise with any change that is proposed; however, I have great confidence that the Commission is working hard toward a goal of building better lives for our disabled veterans and their families.